STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #68223.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

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F 225	Continued From page 1	F 225		

incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 36 residents. The sample included 3 residents identified by the facility at risk for elopement. Based on observation, interview, and record review, the facility failed to investigate and report to a state agency, an elopement by a cognitively impaired resident (#3) identified by the facility at risk for elopement.

Findings included:

- According to the Physician's Order Sheet (POS), dated 9/1/13, the facility admitted resident #3 on 8/17/12. This same POS recorded the diagnosis of dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion).

Review of the quarterly Minimum Data Set, dated 2/26/13, recorded the resident with a BIMS (brief interview for mental status) score of 7 (a score of 0 to 7 indicated severe cognitive impairment),mobility per wheelchair/walker with limited assistance on the unit and extensive assistance off the unit for locomotion.

Review of the Care Area Assessment (CAAs) for cognition, dated 8/30/12, recorded the resident with very poor short term and remote memories, generally oriented to person only. The resident was forgetful of the sequence or steps that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

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F 225	Continued From page 2	F 225		

needed accomplished for any given tasks, due to progressing dementia. The resident demonstrated behaviors which affected cares, refused to allow staff to provide needed cares, yelled, became agitated, delusional, and paranoid at times.

Review of the comprehensive plan of care, updated 3/17/13, recorded the resident with the potential for elopement, used to work as respiratory therapist at the hospital, and sometimes wanted to go there through the dining room door. The care plan directed staff to:
-Pay close attention to the resident's location, especially before and after meals. Answer all door alarms promptly.
-The resident's picture was posted on the elopement roster, since he/she attempted to get out the dining room door to the hospital before.

Review of the initial admission elopement risk assessment, dated 8/17/12, recorded the resident ambulated with a walker, was not safe to ambulate without assistance, and was at risk for elopement. Follow up elopement precaution assessments dated, 11/13/12, 2/19/13, and 5/19/13, recorded a score of 4 and identified the resident as an escapist and at high risk for elopement.

Nursing notes, dated 4/15/13 timed 9:00 P.M., the resident was upset about being at the facility, insisted that his/her car was parked out front with children in the car ... sought exits twice sounding the door alarm for the main door ... continue with close observation.

Nursing notes, dated 4/16/13 timed 2:30 P.M., the resident angry with staff because he/she wanted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3	F 225		

to go home.

Nursing notes, dated 4/18/13 timed 11:16 A.M., documented; staff informed the charge nurse the resident was outside the door on the lower sidewalk in his/her wheelchair. The staff recorded the door alarm on the pager, and reset of the alarm.

Observation, on 9/24/13 at 9:40 A.M. the resident moved about the living room and lobby area next to the nursing station independently in his/her wheelchair.

On 9/24/13 at 3:00 P.M., the resident wheeled him/herself up to nursing station and asked the staff, "Where am I supposed to go?"

On 9/24/13 at 10:45 A.M., the facility provided a list of elopements that identified the resident with an elopement on 4/18/13 at 11:15 A.M. At that time, administrative nursing staff D revealed the previous director of nursing reported the event to the state agency. Administrative nursing staff D provided several witness statements obtained from risk management, however, was unable to locate the investigation.

The facility failed to provide an investigation for the elopement.

9/24/13 AT 1:15 P.M., direct care staff O confirmed the resident mobile and independent in his/her wheelchair and tried to escape or leave.

On 9/24/13 at 5:08 P.M., Activities/Social Services staff JJ, reported at approximately 11:15 A.M., on 4/18/13, he/she found the resident seated in his/her wheelchair outside the building,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 approximately 5 to 7 feet from the senior living center main front entrance, unattended. On 9/24/13 at 4:15 P.M., and again at 5:30 P.M., administrative nursing staff D reported he/she could not find the facility investigation for the resident's elopement, and risk management further lacked the investigation. On 9/24/13 at 4:20 P.M., review with the state agency recorded the facility failed to report an elopement on or around 4/18/13 for resident #3. Review of the facility provided policy, Abuse, Neglect and Exploitation Policy and Procedure, dated 8/2012, and documented the definition of neglect as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness and to ensure safety and well-being. The policy directed it was the responsibility of the manager of the area of the alleged incident to perform a thorough investigation as required by each department's regulations. These parties would promptly inform the Administrator and Chief Nursing Officer of the alleged event. All incidents of alleged neglect were reported to the Risk Management Committee. Any determination of Standard Care at a Level III or Standard of Care at a level of IV were reported to the State licensure/credentialing agency. The facility failed to investigate and report to the state agency, an elopement of a cognitively impaired resident, identified at risk for elopement.	F 225		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

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F 323	Continued From page 5	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 36 residents. The sample included 3 residents identified by the facility at risk for elopement. Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent 2 of 3 cognitively impaired, independently mobile residents (#2 and #3) identified at risk for elopement from leaving the facility unsupervised.

Findings included:

- According to the Physician's Order Sheet, dated 8/1/13, the facility admitted resident #2 on 2/5/13. This same POS recorded the diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion).

Review of the Admission Minimum Data Set (Minimum Data Set) 3.0 Assessment, dated 2/18/13, recorded the resident with a BIMS (brief interview for mental status) score of 2 (a score of 0 to 7 indicated severely impaired cognition). This same Minimum Data Set recorded the resident exhibited wandering behaviors 1 to 3 days of the assessment period and rejected cares 1 to 3 days of the assessment period. The resident required limited assistance for dressing, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

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F 323	Continued From page 6	F 323		

independently ambulatory and balance was unsteady but able to stabilize without staff assistance.

Review of the Care Area Assessment (CAAs) for cognition, dated 2/18/13, recorded the resident with cognitive deficit due to Alzheimer's Dementia (a progressive mental disorder characterized by failing memory and confusion), required time to process spoken information and did not always fully understand information. The resident paced in the facility frequently, was anxious, restless, missing his/her spouse, and identified as an elopement risk.

Review of the quarterly Minimum Data Set, dated 5/15/13, recorded a BIMS score of 2 (severe cognitive impairment), balance not steady but was able to stabilize without staff assistance. The resident required set up assistance from staff for activities of daily living, was independent with transfers, independent with walking and required limited assistance from staff for locomotion off the unit. This same assessment required the resident experienced wandering behaviors 4 to 6 days of the assessment period and at times, rejected cares.

Review of the initial elopement assessment, dated 2/5/13, recorded the resident was ambulatory, not capable of making sound decisions, oblivious to needs or safety, and was disoriented/confused. This assessment recorded the resident was very anxious, wanted to leave and was at risk for elopement. Follow up elopement precaution assessments dated 5/5/13 and 8/5/13, recorded the resident with a wandering classification 4 (escapist), and represented a high risk for elopement. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

elopement assessment dated 8/5/13 documented the resident with successful elopements in the last year.

Review of the initial care plan dated 2/5/13 recorded the resident's comment - " I just want to get out of here. "

Review of the comprehensive plan of care, dated 2/5/13, recorded the resident was at risk for falls, experienced restless and anxiousness, and could be an elopement risk, (when dressed the resident appeared as a visitor and visitors let the resident outside). This plan of care directed staff to:
-Monitor for changes in the resident's condition that may warrant increased supervision/assistance and notify the doctor of staff concerns.
-If staff noticed the resident walking unsafely, walk with the resident, currently a gait belt was not required.
-Pay close attention to the sound of door alarm and respond immediately. Most days the resident was quite interested in the exit doors and needed staff to engage him/her in other interventions.
-Document exit-seeking behaviors.
Addendums to the comprehensive plan of care recorded:
On 5/18/13, the resident was focused on the sun porch door and window and enjoyed watching outside, and waited for his/her spouse to visit. Let the resident walk through the inside neighborhood when restless or while waiting for spouse to come, most every afternoon. Pay special attention to the resident's mood and anxiety level when the resident's spouse cannot come to visit. The resident enjoyed holding and carrying his/her bag/purse when he/she did walk or sit in the living room. The resident read the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

instructions on the doors. The resident was easily engaged in other activities.

Review of the facility provided witness statement information recorded on 6/12/13 at approximately 9:00 P.M., the main entrance door alarmed, and staff identified the resident was walking in the hospital hallway across campus.

Review of the facility provided investigation, recorded on 7/31/13 at approximately 6:00 P.M.; a visitor let the resident out the front door of the facility. At approximately 6:09 P.M., staff identified the resident not in the common area as per usual and implemented a search. Staff found the resident standing outside the facility in the front lawn under a shade tree.

Revision to the resident's plan of care included posting stop signs on all exit doors and encouraged visitors not to let anyone out of the home without asking the charge nurse. Additionally staff placed a red allergy band on the resident's wrist, which the resident removed on 8/1/13. On 8/1/13, staff ordered a " Wanderguard type watch which signaled staff pagers when the resident was approximately 15 feet away from the main entry/exit door. On 8/2/13, staff placed a Wanderguard type watch on the resident's right arm to alert staff when the resident approached the door.

Review of the initial psychiatric evaluation, dated 8/12/13, recorded the resident with impaired insight and judgment.

Review of the facility provided investigation recorded on 8/14/13 at approximately 12:25 P.M.; a visitor assisted the resident outside the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

Another resident at facility notified the staff "that [person] that liked to leave was outside under the shade tree." The facility staff encouraged the resident back inside the facility at approximately 12:31 P.M.

During an interview, on 9/24/13 at 2:30 P.M., administrative nursing staff D reported a visitor let the resident outside on 8/14/13.

Observation on 9/24/13 at 9:40 A.M., revealed the resident sat on a couch in the living room with a Wanderguard watch on his/her right wrist and watched television.

On 9/24/13 at 12:10 P.M., the resident left the dining table and walked independently down the hallway to his/her room.

On 9/24/13 at 4:46 P.M., the resident walked with his/her spouse toward the main entrance/exit door with the nursing staff pager continuous paging until the resident left the area, at least 15 feet away from the door.

On 9/24/13 at 10:21 A.M. administrative nursing staff D reported at least twice every 24 hours (each 12-hour shift), staff tested the Wanderguard system to pager.

On 9/24/13 at 2:50 P.M., licensed nursing staff H reported when staff walked the resident past the front door, the alarm signaled to the pager. When the resident was around 15 feet from the door, the pager signaled. Licensed nursing staff H reported, "I don't keep a record of the placement and function of the Wanderguard.

The clinical record lacked evidence staff checked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

the Wanderguard pager every 12 hours for placement and function.

On 9/24/13 at 10:45 A.M., direct care staff R reported another resident alerted staff that the resident was outside. Direct care staff R revealed the charge nurse designated about every 2 hours, staff who were assigned to monitor the resident and reported that the resident was on 1 on 1 monitoring prior to this incident.

On 9/24/13 at 11:10 A.M., licensed nursing staff I reported the resident always wanted to call home, sat on the couch with a jacket on, and staff watched her closely and provided 1 on 1 staff attendance. Licensed nursing staff I confirmed another resident came to the nursing station and reported to the staff the resident was outside the facility.

On 9/24/13 at 1:15 P.M., direct care staff O reported the resident was an elopement risk. He/she wanted to go out to eat with his/her spouse and now had a Wanderguard bracelet. Direct care staff O revealed staff checked the resident at least every 2 hours and now did hourly checks.

On 9/24/13 at 2:05 P.M., consultant staff KK reported the security camera identified a visitor let the resident out on 8/14/13. Consultant staff KK continued a test of system, proved proper functioning of the Wanderguard and the door alarmed and a message was sent to all the pagers informing them the resident was at the open door.

Review of the facility provided Wanderguard door log, on 8/14/13, recorded at 12:25 P.M., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11	F 323		

resident was present at the main front door with the door open.

On 9/24/13 at 5:15 P.M., direct care staff P, reported the resident was exit seeking, staff tried to watch the resident, and provided one on ones when there was enough staff.

Review of the facility provided undated policy, Management of the Home Free Resident Security System, directed staff weekly on Friday day shift, the charge nurse performed security watch checks and documented on the Nurse MAR (Medication Administration Record) that each assigned security watches lock the appropriate doors. This policy further directed that when a cognitively impaired resident opened any exit door of the facility or had eloped, staff documented 15-minute checks of the residents whereabouts for 24 hours or longer if needed.

The facility staff failed to monitor and document function and placement of the Wanderguard bracelet according to the facility policy. The facility failed to provide supervision and safety of this cognitively impaired, independently mobile resident, identified at risk for elopement, with a history of elopement, from leaving the facility 3 times in 3 months.

- According to the Physician ' s Order Sheet (POS), dated 9/1/13, the facility admitted resident #3 on 8/17/12. This same POS recorded the diagnosis of dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

Review of the quarterly Minimum Data Set, dated 2/26/13, recorded the resident with a BIMS (brief interview for mental status) score of 7 (a score of 0 to 7 severe cognitive impairment), and mobility per wheelchair/walker with limited assistance on the unit and extensive assistance off the unit for locomotion.

Review of the Care Area Assessment (CAAs) for cognition, dated 8/30/12, recorded the resident with very poor short term and remote memories, generally oriented to person only. The resident was forgetful of the sequence or steps needed to accomplish any given tasks, due to progressing dementia. The resident demonstrated behaviors which affected cares, refused to allow staff to provide needed cares, yelled, became agitated, delusional, and paranoid at times.

Review of the comprehensive plan of care, updated 3/17/13, recorded the resident with the potential for elopement, used to work as respiratory therapist at the hospital, and sometimes wanted to go there through the dining room door. The care plan directed staff to:
-Pay close attention to the resident's location, especially before and after meals. Answer all door alarms promptly.
-The resident's picture posted was on the elopement roster, since he/she attempted to get out the dining room door to the hospital before.

Review of the initial admission elopement risk assessment, dated 8/17/12, recorded the resident ambulated with a walker, was not safe to ambulate without assistance, and was at risk for elopement. Follow up elopement precaution assessments dated, 11/13/12, 2/19/13, and 5/19/13, recorded a score of 4 and identified the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13	F 323		

resident as an escapist and high risk for elopement.

Review of the nursing notes, dated 4/13/13 timed 9:00 A.M., documented the resident continued to be confused and wanted to leave.

Nursing notes, dated 4/13/13 times 6:30 P.M., the resident insisted he/she needed to go home, made up reasons why he/she was looking for car, keys, ...continued to monitor behavior and keep the resident safe.

Nursing notes, dated 4/15/13 timed 9:00 P.M., the resident was upset about being at the facility, insisted that his/her car was parked out front with children in the car ... sought exits twice sounding the door alarm for the main door ... continued close observation.

Nursing notes, dated 4/16/13 timed 2:30 P.M., the resident was angry with staff because he/she wanted to go home.

Nursing notes, dated 4/18/13 timed 11:16 A.M., social services designee informed nursing the resident was outside the door on the lower sidewalk in his/her wheelchair. The resident leaving came across to the pagers.

Observation on 9/24/13 at 9:40 A.M. the resident moved about the living room and lobby area next to the nursing station independently in his/her wheelchair.

On 9/24/13 at 3:00 P.M., the resident wheeled him/herself up to nursing station and asked the staff, "Where am I supposed to go? "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 On 9/24/13 at 10:45 A.M., the facility provided a list of elopements which identified the resident with an elopement on 4/18/13 at 11:15 A.M. On 9/24/13 at 1:15 P.M., direct care staff O confirmed the resident was mobile and independent in his/her wheelchair and tried to escape or leave. On 9/24/13 at 2:50 P.M., licensed nursing staff H confirmed the resident was an elopement risk. Staff kept an eye on the resident around the nursing station and when he/she was not there, staff walked around to look for him/her. On 9/24/13 at 5:08 P.M., Activities/Social Services staff JJ, reported that at approximately 11:15 A.M., on 4/18/13, he/she found the resident seated in his/her wheelchair outside the building, approximately 5 to 7 feet from the senior living center main front entrance, unattended. The facility failed to provide supervision and safety of this cognitively impaired, independently mobile resident, identified at risk for elopement, from leaving the facility.	F 323		